When the Government of India Act of 1919 was being passed, a system of dyarchy was to be introduced. The Montague-Chelmsford report was to show how to divide the government into two parts and to recommend which departments should be transferred to India. That Report laid down four conditions to decide whether a department should be transferred or not:

1. A subject in which India has shown great interest to be transferred.
2. A subject in which there are plenty of opportunities for social service.
3. A subject in which mistakes are not likely to be made.
4. A subject in which mistakes even if made are not going to be very disastrous.

Education came under all the four conditions and was transferred. That basic attitude remains unchanged to this day. That is why I have really given up the hope of the Planning Commission ever preparing a long term perspective plan.

The point is, if we want such a plan there has to be a sustained official initiative. Somebody, some group of people, have to take it upon themselves to do this. The Carnegie Commission in the United States was a Commission on Higher Education. The US had no plan for any subject including education, but there was a group of people who thought there must be a long-term perspective plan for higher education because in so far as school education was concerned it was already universal. The only area which they thought was the weakest was that of higher education. So the Carnegie Commission undertook a number of studies and prepared an eight-year plan of development for higher education in the United States. Such a plan once prepared, will certainly have a deep effect in educating public opinion, in moulding policies and so on. I think something similar would happen even in India if we really were to do it.

What I would say is that there is challenge to educators who are interested in the building up of a good educational system in the country. It is not necessary that they should agree. In fact they should have sharp differences of opinion, contrasting or opposite views and people should come forward with one, two, three or even four plans.

If we begin now, we are not beginning too early and if what you do may not have an effect on the Sixth Plan it will certainly have an effect on the Seventh and later plans and this is something I would request educational institutions and educationists to do today.

J. P. Naik

An Alternative System of Health Care Services in India : Some General Considerations*

The Search for an Alternative

I attach great importance to the word 'alternative' in the theme of this oration. Let me, therefore, explain in some detail what I have in mind.

When we became free, we decided to expand and improve the health services of the country as one part of a comprehensive package of programmes then undertaken to raise the standards of living of the people. Our approach to the problem, however, was rather simplistic. We adopted the western model of health services which, we thought, was ideally suited for our country. It may be pointed out that our doctors were then being trained in institutions which maintained standards comparable to those in England and thus got an automatic right to practice or serve in the U.K. The basic emphasis in this model was on the adoption of the latest medical technology developed in the West and to make it available to the people of this country through,

- the expansion of the bureaucratic machinery of the medical and public health departments,
- the expansion of the institutions of medical education to train the agents required for the delivery of health care (such as doctors or nurses),
- the creation of the necessary infrastructure needed for the purpose from the big hospitals in metropolitan cities to the primary health centres and dispensaries in rural areas, and
- the indigenous production of the essential drugs and chemicals required.

* The fourth Sir Lakshmanswami Mudliar Oration delivered at the Sixteenth Annual Conference of the All India Association for the Advancement of Medical Education, at Chandigarh on Saturday, 12 March, 1977.

There is no doubt that we have achieved a good deal during the last 30 years if judged by the targets we thus set before ourselves. There is now a huge Ministry of Health and Family Planning at the Centre and large departments of public health and medical services in the States. The doctor still remains the principal agent of health care and there has inevitably been a concentration on his training. As against 15 medical colleges with an admission capacity of about 1,200 per year in 1947, we now have 106 colleges with an admission capacity of about 12,500 per annum. The standards of training were also 'upgraded' with the abolition of the shorter licenciate course and the introduction of a uniform course of 4½ years (after 12 years of schooling) for the first medical degree. The facilities for training other functionaries — whose categories have greatly multiplied — were also increased substantially so that we are not far from the norms proposed by the Bhore Committee. A huge infrastructure of hospitals, Primary Health Centres and their subcentres, and dispensaries has also been built up. The pharmaceutical industry has been developed almost from a scratch. It now produces several life-saving drugs and its output has increased from about Rs. 10 crores a year in 1947 to about Rs. 105 crores a year at present. There has also been immense progress in the control of communicable diseases such as cholera, malaria and small-pox. That there is considerable improvement in the health status of the people due to all these measures, is established by three main indices, viz., the increase in life expectancy from about 32 years in 1947 to about 52 years at present, the fall in death rate from about 27.4 per thousand in 1947 to about 11.3 per thousand at present, and the decline in infant mortality from about 160 per thousand live births in 1947 to about 125 per thousand live births at present.

Impressive as these achievements are — and we have every right to be proud of them — it is also realized that our failures are even more glaring. For instance, we have found that the present system provides health care services mostly in the urban areas and for well-to-do people and that it does not reach the poor people in rural areas and urban slums. The funds required to extend these services to these excluded groups will be almost astronomically large and there is no possibility of getting them within the foreseeable future. There is considerable dissatisfaction about the education of doctors. We are also not sure of what kind of a doctor we need, how to train him, and even more importantly, how to harness him to the service of the rural areas or poor people. The same can be said of other functionaries as well. The infrastructure we have built is also mostly urban and beyond a few pilot experiments — whose value and capability for generalization are still in question — we do not have clear ideas about the infrastructure and health care delivery agents needed for rural areas. The system is still over-weighted in favour of curative programmes in spite of

the clear conviction that, in our present situation, it is the preventive, socio-economic and educational aspects of health care systems that are the most significant. What is even more important, we are no longer sure that the western model we adopted is really suited to us, especially as its basic premises are now being challenged in the West itself by thinkers like Ivan Illich. We have also realized that no bureaucracy, however large and efficient, can be a substitute for the active involvement and education of the people in programmes of health improvement. In short, after thirty years of development of health services, we find ourselves in the position of a traveller who sets out on a long journey, and even before he has travelled about three-tenths of the distance to his goal, finds that his purse has been stolen, his car has developed serious trouble and grave doubts have arisen even about the correctness of the route he had decided to follow.

Therefore, I find a qualitative difference in the situation in the last five years. Earlier, the assumption at least was that we are on the right track and that all that was needed was a good deal more of the same thing, and that we would be able to achieve our goals if more funds were provided and the quality of implementation were improved. Today, there is a growing awareness that what we need is not 'more of the same' but something 'qualitatively different'. This is what I mean by the search of an alternative; and the Report of the Srivastava Committee is perhaps the first recognition that some alternative or alternatives are needed. I am very happy that we have begun to grapple with this basic problem in right earnest. I hope we will continue this effort intensively over the next two years and succeed in evolving a viable alternative, economic, health care policy which can become the core of the Sixth Five Year Plan. All that I aspire to do in this oration, with your kindness and collaboration, is to make some contribution to promote this extremely significant national endeavour.

The Basic Issues

Let me preface my detailed and concrete proposals on the subject, which I will discuss in the following section, by a statement of what I consider to be the three basic issues of development in all sectors of our life to which the development of health care systems is no exception.

The first refers to the fundamental question of the type of society we want to create in India. Mahatma Gandhi was convinced that we would have to evolve our own model of such a society in keeping with our traditions, present conditions, needs, and future aspirations. "Let the winds from all corners of the world blow in through the windows of my house", he said, "but I refuse to be blown off my feet by any". He also initiated a

dialogue on the kind of society we must create and sustained it throughout his life. But unfortunately that dialogue disappeared with him; and we have almost equated 'modernization' with 'westernization' and are content with the introduction of a pale imitation of western models in our country. But social models cannot be so transferred, and even if they are, they will hardly be useful. There is, therefore, no escape from the earnest intellectual exercise of deciding for ourselves the kind of society we would like to have and the model of health care systems that we should build up. In this, we may be *guided* by the experience of the West (or of the whole world) but not *conditioned* by it.

The second issue refers to the dichotomy between our professed goals which are explicitly stated and to which generous lip sympathy is paid in season and out of season, and the hidden implicit goals which we really pursue. Before independence, we made a number of solemn pledges to the people of India in whose name we fought for political independence, viz., that we shall abolish poverty, ignorance and ill health and raise substantially the standards of living of the masses. In the euphoria of freedom, we also embodied these assurances in the Constitution whose Preamble commits us to the creation of a new social order based on freedom, equality, justice and dignity of the individual. These, therefore, are our professed goals; and the attainment of independence places our well-to-do educated classes (who now hold all the positions of power surrendered by the British authorities) on trial by challenging them to achieve these objectives. We are also compelled to pay lip sympathy to these goals because we have adopted a system of parliamentary democracy which forces us to solicit the votes of the people and because we find it convenient and easy to do so on these populist slogans. But the achievement of these goals is not an easy thing and it is also not in our immediate self-interest to do so. We therefore, adopt hidden and implied goals of pursuing our own class-interest. This is understandable (but not excusable) because a ruling class rules, first and foremost, for its own benefit and only incidentally for that of others. Thus develops a dichotomy wherein we talk of serving the masses of people, the *Daridranarayana* of India, while in reality we are more busy than ever in aggrandizement for the benefit of our own classes. In fact, we have converted this very dichotomy into a fine art so that, today, the best and the quickest way to become rich and powerful is to follow in the footsteps of the Mahatma and to offer one's life to the service of the *Daridranarayana*. It is necessary that we abandon this double-think and double-talk and devote ourselves in all earnestness to create an egalitarian society in India.

The third issue refers to the first steps and the process through which this egalitarian transformation can be brought about. When it comes to the discussion of an egalitarian and more just international economic

order, we lose no time in declaring that no such transformation is possible unless the rich nations first cut down their artificially inflated standards of living (which are not good for them, either) and that we must accept a 'mini-max' philosophy under which no one gets less than what is needed for decent human existence just as no one is allowed to have an affluence beyond a certain level which also degrades. Exactly the same principle applies to the national situation also. But here we want to proceed on the assumption that the maintenance and continuous levelling up of the standards of living of the well-to-do must have the first priority on all development plans and that the programme of providing even the minimum levels of living for the underprivileged and the poor should be attempted to the extent possible *after* the demands of the well-to-do are first met. The problems of developing countries like India cannot be solved with this approach; and we must be prepared to share poverty with the people and deliberately and voluntarily agree to cut down our conspicuous consumption, our unnecessary expenditure and our affluent 'necessaries' in order that the poor may have some fair deal. This, let me emphasize, is not a policy against the well-to-do classes. In fact, it is the only policy in support of their enlightened self-interest and the larger interests of the country as a whole. What Gandhiji meant by his doctrine of 'trusteeship' was the adoption of this policy by the ruling classes, voluntarily and willingly.

At present, our policies are mainly directed to the borrowing of some western model or the other and to advance the well-being of the well-to-do classes, in spite of all our populist slogans to the contrary. If the three basic shifts in policies discussed here are not made, we shall be continuing the same old class-oriented programmes based on the adoption of wrong technologies, with marginal changes which will deceive none and which will achieve but little in improving the conditions of the deprived groups. It is, therefore, obvious that out search for alternatives in health care systems must be based on these three unexceptionable principles.

Linkages with Other Sectors

No system of health care can be considered in isolation. For instance, the health status of a people at any given time will depend upon several factors such as the following :—

– Health care systems are obviously related to concepts of health and disease. For instance, the health care systems in a society which believes that all sickness arises from the wrath of gods or evil spirits will be different from those in a society where illness is held to arise from material causes which need a treatment in tangible, material terms. Similarly, the health care system in a society which believes in individual responsibility for health through proper exercise, regular habits and

self-control will be different from that in a society where the individual is allowed every license and its evil results are attempted to be corrected through medical or other intervention. Similarly, attitudes to pain, ageing or death also determine the nature of health care systems.

- Health care systems also depend upon ecological factors. We need pure and fresh air, good and safe drinking water, adequate drainage and proper disposal of night soil, proper housing and adequate arrangements for immunization and control of communicable diseases, if illness is to be prevented, and if satisfactory conditions are to be created where we can hold the individual fully responsible for his health.

- Health status and hence health care systems, also depend upon social and economic factors such as the organisation of the home and family, equality or otherwise of the sexes, social stratification, general conditions of work and poverty which increases proneness to disease while decreasing the capacity to combat it.

- Health is closely related to nutrition and depends upon such factors as the quality and adequacy of food supplies, dietary habits and concepts and culinary and food preservation practice.

- Health care systems are also obviously related to the technology of medicine and to our knowledge of and ability to deal with the malfunctioning of the body.

- Health is also closely related to the spread of education among the people because an individual's understanding of health, his capacity to remain healthy and his ability to deal with illness are all conditional upon the level of his education. The nature of health care system in a society where every individual receives a good basic education will therefore be very different from that in another society where the bulk of the people is illiterate.

Some of these factors fall within the sphere of health services and will be discussed here in some detail. Others like nutrition, poverty, or general education of the people are obviously important but fall outside the limited scope of this oration. It is, however, obvious that a good system of health services cannot be built in isolation. It will have to be an integral part of a wider programme to improve the standards of living of the people and will have to be linked to programmes of abolishing poverty, achieving larger production and better distribution of food (including proper storage and improved dietary and culinary practices), and universal basic education. Family planning will, on the one hand, help the adoption of such an integrated approach, and on the other, it is the adoption of this comprehensive approach that will facilitate and promote a good programme of family planning.

Some General Conditions

No single individual can be expected to produce an alternative plan for the health care systems of our country. This is essentially an institutional and group task. I am, therefore, sure that you do not expect me to place such a plan before you. But you would be justified in expecting that I would at least place before you a few broad principles on which the alternative plans should be based and that I at least initiate a dialogue on the basis of which the preparation of such a plan (or plans) can be undertaken by appropriate groups and agencies in due course. It is precisely this that I shall attempt to do in the limited time at my disposal and place a ten-point programme before you for detailed examination.

(1) *Target Groups*: My first proposal in this context is that we should state, beyond any shadow of doubt, who the beneficiaries of these alternative systems of health care will be. We should also ensure that these proposed systems will not be so implemented that their benefits again go to those very groups who receive the lion's share of health care under the existing system.

Our developmental experience in the last thirty years shows that we have often gone wrong on both these counts. Several of our schemes of production (e.g. cocoa cola, canned or readymade foods, cosmetics, automobiles, cigarettes or superfine cloth) were meant to produce not the essential basic consumer goods required by the masses but the luxury and semi-luxury goods needed by the well-to-do classes. The largest beneficiaries of the development of science and technology and of our industrial development based on the concept of import-substitution, have, therefore, been the middle and the upper classes and not the masses of the people. On the other hand, several schemes which were originally planned with the object of helping the poor and deprived groups were so distorted in implementation that their benefits also went to the well-to-do. For instance, many a scheme of helping the Adivasis or landless labourers through employment or subsidies resulted merely in passing funds to the money-lender or rich peasant who exploited the Adivasi or landless labourer. The fishing industry in Kerala developed with Norwegian collaboration was originally intended to improve the diets of poor fishermen. But when it adopted high technology, it naturally wished to make adequate profits and with this objective in view, it concentrated on catching prawns. While these prawns continued to be eaten in Tokyo, Paris, London, Bombay, or Delhi and the industry made huge profits, the diet of the poor fishermen (whom the scheme was to benefit) continued to be the same or even became worse.

Such distortions were found within the health care services as well. If contributory health insurance schemes were to be introduced on a selec-

tive basis, the Central Government Employees are certainly not the most eligible group of citizens to be covered first under the scheme which involves a heavy subsidy. Even within the scheme, the per capita expenditure on the senior officers (deputy-secretary and above) is much larger than that on the class IV employees. The same can be said of all the infrastructure of big hospitals and super-specialities which benefit largely the well-to-do. We expanded the facilities for the training of doctors on the plea that they are needed for rural areas. But our actual experience is that the majority of the doctors we train go abroad or settle down in urban areas. The trained A.N.M. attached to the Community Development Block was meant to help the poor families. But she has actually become handmaiden to the rich and powerful rural elite. Similarly, several schemes meant specifically for rural areas and the poorer people have made no headway in practice. For instance, the programme of training village *Dais* has continued to languish; and as Professor Banerji points out in his admirable booklet on *Formulating an Alternative Rural Health Care System for India* (pp. 7-8) "In 1963, a Government of India Committee recommended that rural populations may be provided integrated health and family planning services through male and female multipurpose workers.[1] But the clash of interests of malaria and family planning campaigns soon led to the reversion to unipurposes workers. In 1973, yet another committee revived the idea of providing integrated health and family planning services through multipurpose workers.[2] This time also the prospect of effective implementation of the scheme does not appear to be very bright. Earlier, there had been at least two more efforts, both similarly abortive, to develop alternative health strategies. One, the so-called Master Plan of Health Services envisaged (in 1970) more incentives to physicians, establishment of 25-bed hospitals and use of mobile dispensaries for remote and difficult rural areas.[3] The other, apparently inspired by the institution of Barefoot Doctors of China, was to mobilise an estimated 200,000 Registered Medical Practitioners of different systems of medicine as "Peasant Physicians" to serve as rural health workers."[4]

During the British period, our health care systems were based on the idea of making modern medical and health technology available to a class of people who were well-to-do and mostly urban. In spite of all that we have said to the contrary, the same policy has been continued substantially

1 India, Government of, Ministry of Health, *Committee on Integration of Health Services, 1963.*

2 India, Government of, Ministry of Health, *Family Planning Committee on Multi-purpose Workers, 1973.*

3 *Outline of the Master Plan for the Provision of Health,* Medical and Family Planning Services in Rural Areas, 1970.

4 National Health Scheme for Rural Areas (Revised) 1972.

during the last thirty years. Even today, about 70 per cent, of the people do not have access to even the most elementary health care services. This cannot be allowed to continue; and one acid test of all proposals for alternatives should be that they should really benefit, in planning as well as in implementation, the poor and deprived people living in rural areas or urban slums. The talisman that Gandhiji suggested is very relevant in this context; whenever one has to decide the priority or desirability of a plan, one must always relate it to the extent to which it will actually benefit the poorest and the lowliest of the low.

(2) *Emphasis on Preventive and Protective Aspects*: My second proposal is that the new health care systems we propose to develop as alternatives should move away from the over-emphasis which the existing systems place on mere curative measures and must place a much greater emphasis on preventive and protective measures to which a large bulk of the available resources should be devoted. For instance, our achievements in making better nutrition available to the people are by no means impressive; and even today, very large sections of people go without adequate food. It is true that the total available food supply has increased. But the production of coarse foodgrains, on which the poor people mostly live, has not kept pace with the increase in the numbers of the poor. We have hardly any system of public food distribution in rural areas (outside Kerala). Nor have we made any sizable impact on the capacity of the poor to buy food in the market. Provision of protected water supply has been made for four-fifths of the urban population but nearly 120,000 villages with a population of more than 60 million people do not still have even the most elementary water-supply system. Sewerage exists only for 40 per cent of the urban population. Most medium and small towns have no sewerage systems and in the rural areas, the programmes of drainage and sewerage are nowhere in sight. It is true that considerable progress has been made in the control of cholera, small-pox and malaria. These gains need to be conserved and developed further. But the prevalence of infections in general and intestinal infections in particular is still large; and in several areas, a vicious circle has already been established; infection leading to malnutrition and malnutrition in its turn leading to increased proneness to infection. It may be asserted without fear of contradiction that under the present conditions in India, protective and preventive measures are even more important than curative ones. The alternative plans we propose to develop must, therefore, lay a greater emphasis on them.

(3) *Choice of Technology*: The third basic issue in which the alternative plans blaze a new trail is that of health and medical technology. The policy adopted so far, and this is true of all spheres of life including health, has been to consider technology as sacrosanct and above all laws.

We have always tried to introduce in India the most highly developed technology the world has discovered on the assumption that our people should have nothing less than the absolutely first-rate available anywhere else in the world. As the over-riding principles in the choice of technology are its modernity and advanced character (and not suitability to the people), we generally expect the people to adjust themselves to technology rather than the other way round. These policies, I am sorry to say, have been proved to be wrong and counter-productive. It is now universally agreed that technology cannot be an end in itself. It can only be a means to an end, viz., the welfare and growth of the people so that we must choose a technology best suited to the interests of the people and not expect the people to adjust themselves to the technology. Secondly, we have now learnt that the choice of technology is extremely crucial because it affects priorities, target groups, investment levels, and the character of the delivery agents. A higher level of technology requires a larger investment; it needs a more highly trained and sophisticated delivery agent; and its benefits tend to accrue to a smaller and more privileged social group. It is, therefore, our decision to adopt the best health and medical technology available in the world that has led to the creation of the present system of health care services in the country, oriented to the well-to-do classes and which is in the words of Professor V. Ramalingaswamy, over-centralized, over-expensive, over-professionalized, over-urbanized and over-modified.[5]

The question, therefore, is whether it is always necessary for us to 'soar' upwards in the technological ladder as we have done. That this is not absolutely essential is evident from several important experiments. The Chinese developed a workable system of health care oriented to the people, with the help of barefoot doctors. Cuba did an equally creditable job with unsophisticated personnel. Garl Taylor trained illiterate Muslim women in Noakhali to perform tubectomy. In our own country, Dr. Raj Arole at Jamkhed has trained illiterate village women to take care of 70 per cent of the common illnesses of the local community. Dr. C. Gopalan is prepared to train the village teachers for the delivery of curative services for day-to-day illnesses. These illustrations lead to two conclusions. The first is that there are, as Wordsworth has pointed out, two types of the wise — those that 'soar' upwards to the stars and those that 'roam' far and wide on this our earth. We tried to 'soar' and the Chinese decided to 'roam'. Perhaps it would be more correct to say that this is not really an 'either-or' issue and we must have both types of the wise, those who soar and those who roam, in a proper combination and a fruitful organi-

[5] It should be noted that a decision to climb upwards in the technological ladder leads exactly to the same results in other fields of life as well. For instance, a bicycle can be used by every one; but the use of faster means of transport continually increases costs, needs more sophisticated personnel and restricts the beneficiaries.

sation dictated by the needs of the country. This is what the Chinese seem to have done while we decided only to soar. Secondly, it appears that even high technology lends itself to two kinds of treatment. We can mystify it and restrict its use to only a few highly sophisticated and professionalized individuals. On the other hand, we can demystify it and train even the unsophisticated non-professionals to handle it. The best illustration is that of the agricultural scientists who take pride in demystifying even the highest technology and placing it in the hands of even illiterate farmers. Innovators like Carl Taylor, Raj Arole and Gopalan have shown that this can be done in the field of health services as well. Why can't we have more of the same ?

Whatever the decision on this issue may be, let us not forget one significant factor, viz., the type of health care systems we develop will depend upon our choice of technology to be adopted. What we have done in the existing health care systems is that we first introduced, in a few of our metropolitan cities, a technology that existed in London and then tried to spread it to the 'periphery' where the mass of the people live. The attempt has failed and cannot succeed. Can we not instead begin with the local community and with such local technologies as already exist ? This can be a real alternative. As Professor Banerji writes :

"An obvious framework for suggesting an alternative to the existing approach of "selling" some technology to the people will be to start with the people. This will ensure that technology is harnessed to the requirements of the people, as seen by the people themselves — i.e. technology is subordinated to the people. This alternative enjoins that technology should be taken with the people, rather than people taken with technology by "educating" them.

"Based on their way of life, i.e. on their culture, people in different communities have evolved their own way of dealing with their health problems. This concept forms the starting point, indeed the very foundation of the suggested alternative for immediate action. People on their own, seek out measures to deal with their health problems. Meeting of the felt needs of the people which also happen to be epidemiologically assessed needs receives the top priority in such a framework for an alternative. People should not be "educated" to discard the measures that they have been adopting unless a convincing case is made to show that taking into account their own perspective of the problems and under the existing conditions of resource constraints, it is possible to have an alternative technology which will yield significantly greater benefits to people in terms of alleviation of the suffering that is caused by a health problem.

"As is the way of life, health behaviour of a community is a dynamic phenomenon; it changes with changes in the epidemiology of the health problems, available knowledge relating to such problems, availability of resources and other such considerations. Therefore, to be based on such a dynamic phenomenon, the alternative for immediate action is required to be correspondingly accommodative."[6]

(4) *Agents of Health Care* : The fourth issue relates to the nature of the agents we should select and train for health care services.

The tradition in ancient India was that services needed by the people were provided by selected persons within the community itself, who generally worked on a part-time basis and provided their services, either free of charge or at a nominal cost which the people could afford. The village *Dai* is a good example of this pattern. She has survived to this day and is still delivering her services to 95 per cent child births in rural areas. There was thus specialisation without professionalization. The negative aspect of the situation was that the technology available was crude and did not grow. On the other hand, its positive features were that the services did reach the masses of the people and that their human aspects (which modern professionalism has killed) were superb.

Instead of trying to develop this model by preserving its strength and improving the level of its technology, we decided to ignore it altogether and adopt the western model of paid and full-time professionals to provide the health services (and other services as well). The village *Dai* was treated with contempt and was to be replaced by an A.N.M., the village *Vaidya* or a *Hakim* by a modern doctor, and so on. The main reason for this decision was the belief (and obviously uncritical belief) that the new and modern technology we wanted to introduce could not be taken to the people through these old agents: new wine needs new bottles. The consequences have been disastrous. The new professionals are so costly that we cannot afford to employ enough of them with the result that we provide these services only to a small group of well-to-do people. What is worse, the humane qualities of the old agents are more absent than present in these modern, technically more competent, but mercenary new agents.

The hard choice we have to make is, therefore, clear : Should we go back to the old traditional model, or go ahead with the new model or combine both ? We just do not have the resources to provide these modern agents of health to *all* our people. Nor can we totally ignore these modern health agents and their technical competence. We must not, therefore, regard this as an "either-or" issue. We need both the types in an appropriate combination. For instance, we just cannot provide A.N.Ms to *all*

[6] D. Banerjee; op. cit., pp. 13-14.

the deliveries in rural areas. This is also unnecessary. The village *Dais* must, therefore, be trained and utilized to provide usual antenatal and mid-wifery services. But they should be trained to detect, and refer in good time, all complicated cases to the PHC or other centres where more highly trained functionaries will deal with them. What is said of the mid-wifery services here will also apply to other services. Instead of mystifying the services and centering them in the hands of full-time professionals (which only implies that these services will be costlier and limited to a few), we should simplify the services into several components which can be efficiently managed by para-professionals and non-professionals and train people from within the community to deal with them. This modified form of de-professionalization is desirable, even if we had the money to provide professional services alone (rich countries which have relied exclusively on fully-paid professionals for basic services have regretted their decision and are trying to go back to the earlier stage) because it is a more humane way of doing things which gives a meaning to the lives of hundreds of workers. When we do not have the resources, there is no alternative to this at all. There need also be no fear that such carefully planned deprofessionalization will reduce standards. In fact the work of Taylor or Arole shows that it improves standards. That is why I would strongly urge the full implementation of the proposals made by the Srivastava Committee for the training of health agents at the community level from among the community itself. I, therefore, fully support the following proposals made by Prof. Banerji :

"Community members may be encouraged to make maximum use of self-care procedures through continued use of various home remedial measures. Services of locally available practitioners of various systems of medicines should be used as a supplement. Another supplementary community resource can be created by providing training to community selected primary health workers, who are specifically drawn from among the weaker sections, who can make available home remedies and remedies from the indigenous and western systems of medicine for meeting the medical care needs. Services of full-time health auxiliaries may be used only to tackle more complicated cases and those which need more specialised care."[7]

Prof. Banerji makes this recommendation for medical care only. But it would apply to all categories of health services.

(5) *Infrastructure* : The fifth issue refers to the infrastructure that is needed to deliver health care to the people. Here I would like to highlight five points.

[7] D. Banerji, op. cit., pp. 14.

(a) The existing infrastructure over-emphasises the provision of hospitals and specialities and super-specialities. The present trend also is to increase this emphasis. But as we have seen, this only increases costs and tends to benefit the well-to-do few. There is also evidence to show that a fairly large proportion of hospital beds are actually utilized for cases which need not have been hospitalized. There is no point in adopting a target from western countries and say that we must have one hospital bed for so many people. This is no indicator of health at all and is not a model that suits us or we should follow. We should encourage a greater use of home for treating illness. The well-to-do may also be free to have private nursing homes if they so desire (it is senseless to control them). But the role of public-supported hospitals should be re-defined and de-emphasised. We may even refuse to set up new hospitals in urban areas and use the existing ones for the poorer people (the rich being compelled to go to private nursing homes). In the rural areas and smaller towns, however, small hospitals (or even mobile hospitals) may be encouraged.

(b) The greatest weakness of the present infrastructure is that the area below the PHC is almost blank. Here we need to put in the largest effort. We must adopt the recommendation of the Srivastava Committee that a real primary health centre (or a mini health centre or a sub-centre) should have population of about 5,000 with two para-professional workers — one male and one female. They should work in close collaboration with several local health-workers for the community itself. The PHC can then function efficiently as an appex organisation for all these groups at the mini or sub-centres.

(c) The referral services need to be strengthened and streamlined so that every citizen has a reasonably equal opportunity to avail himself of the specialities or super-specialities he may need.

(d) The education programme needs a total overhaul. There should be a Medical and Health Education Commission as recommended by the Srivastava Committee. The training of the basic doctor needs over-hauling and its costs reduced. The over-emphasis on post-graduate work needs to be reconsidered. There is absolutely no justification to start any new medical colleges. In fact, some of the existing ones may be closed or converted to other uses.

(e) Most important of all, we have to create institutions and channels for the training of thousands and thousands of the new health agents we need — the para-professionals and non-professionals. Special emphasis will have to be laid on the use of non-formal channels in those programmes. The status and quality of this training would have to be very high and appropriate bridges will have to be built between the training and the education of the professionals.

(6) *Drugs*: The adoption of modern health and medical technology also implies the production of modern drugs needed by the technology. A modern pharmaceutical industry is, therefore, an integral part of the modern health care systems.

The progress made by the modern pharmaceutical industry in India can be briefly summarized as follows:

(a) The pharmaceutical industry now produces drugs worth Rs. 450 crores (1975) as against Rs. 10 crores in 1947 — a phenomenal increase of 45 times. It has achieved outstanding results in import substitution and also exports drugs worth about Rs. 25 crores. It has been able to secure collaboration with many advanced countries and has also developed a good research and development programme of its own.

(b) There has been an expansion not only in the quantum of production but in its variety also. The drugs now manufactured by the industry cover a very wide therapeutic spectrum ranging from anti-biotics to vitamins.

(c) The public sector represents 30% of the capital investment in this sector. It also represents 27 per cent in bulk drugs and 7 per cent in formulation.

I would like to highlight three issues here:

(a) In all developed countries, the pharmaceutical industry has become a vested interest in ill-health. It has set up a tremendous propaganda apparatus and uses the medical men practically as its salesmen. It is this vested interest which leads to a proliferation of drugs (where none is needed), to increasing costs of drugs, to over-medication and to distortion of values. These are dangers of which we should be forewarned. These have already begun to appear in our midst; and we might do well to nip them in the bud.

(b) I feel most irritated by the type of propaganda the drug industry puts up and we uncritically swallow. For instance, a beautiful brochure brought out by the industry emphasises that the consumption of drugs per head in India is Rs. 7.5 as against Rs. 310 in USA and observes: "The per capita consumption of drugs is a fairly reliable index of the State of development of the health care system judged by this standard, our country has a long way to go in this vital field.[8] One cannot easily accept the view that the increasing consumption of drugs is an indication of better health. I do not also agree that the average Indian is in greater need of drugs than of food. I might also point out that the average citizen in USA

[8] Organization of Pharmaceutical Producers of India, *The Nation's Health and Pharmaceutical Industry*, Bombay, 1976, p. 25.

spends about Rs. 35 on sleeping pills per year which is more than what we spend on the education of our average citizen. Very probably, we might reach the target of sleeping pills even before we achieve the targets in milk consumption or education.

(c) We need a far more intensive effort to produce the common drugs needed by the people and to make them available at the cheapest prices possible. The present tendency to produce fancy and costly goods for the well-to-do has to be replaced by the mass production and cheap sale of drugs needed by the common man.

(7) *Involvement of the People*: One unfortunate aspect of the post-independence administration is the over-emphasis on bureaucracy and failure to involve the people intimately in development. From 1921 to 1947, Mahatma Gandhi had mobilized the people and involved them, not only in the national struggle for freedom, but also in several constructive programmes like removal of untouchability or promotion of village industries and handicrafts. If this tradition could have been continued and intensified in the post-independence period, the story of our development would have been entirely different. But somehow this was never done. The Government of free India expected only one thing from the people; they should vote them to power every five years. The Congress never built up cadres and never tried to organize mass movements round specific developmental issues and the opposition parties also did not do the effort and they did not also matter. Consequently, the full responsibility for the implementation of development plans was placed on the bureaucracy which increased several-fold in every sector. There is no doubt that the Indian bureaucracy is fairly efficient as bureaucracies in developing countries go. But the basic issue is that no bureaucracy, however large and efficient, can ever succeed in the proper implementation of the national plans of development on its own exclusive responsibility. Development means making the people aware of their problems and of the possible and alternative solutions to them. It also means enabling the people to take decisions, to try out solutions, to evaluate their progress and to modify their strategies, and so on, till the problems are solved. In this process, the bureaucracy certainly has an important role to play. But it has to be a subordinate role and the major task is still to be done by the people themselves through a nation-wide mass movement. While this is essential in every sector of development, it is absolutely necessary in sectors like education and health where progress is to be measured essentially in terms of individual awareness and growth. After all is said and done, health is as much a function of the mind as of the body and no system of health care services can succeed except through the willing and enthusiastic co-operation of the people. This can be secured only through a mass educational movement. Unfortunately, no such movements were ever organised (except to some extent in the control of communicable diseases) so that the health care systems did not really take off the ground in the proper sense of the term. The continuance of these policies will again lead to the same disastrous consequences. We must, therefore, plan our future programmes only on the basis of mass participation.

(8) *Educational Aspects*: The necessity for the massive involvement of the people in health care systems is best illustrated with reference to their educational aspects. For instance, it is necessary to educate all the people and every individual without exception — to unlearn the wrong concepts of health and disease, to understand the basic principles of hygiene, to discipline oneself, to learn to practise self-medication to the extent necessary, and to discharge all one's personal responsibilities towards one's own health. The people must also be trained to adopt mature attitudes to ageing, pain and death because it is the superstitions and irrationalities in these matters that form the fertile soil for the growth of most of what is wrong in the present systems. In this regard, the Indian contribution of the concept of four *ashrams* is superb. Every one begins his life as a fondled child and then becomes successively a *Brahmachari* or a disciplined student, a *Grihastha* or house-holder when he drinks deep at the spring of life in all its fullness, a *Vanaprasthi* or a retiring and retired person, a *Sanyasi* who renounces the world and contemplates upon God, and finally gets ready to welcome death which becomes, not a terror, but a fulfilment in which the individual merges in the eternal and the absolute. To make every individual realise and practise this concept is equivalent to laying down the spiritual basis of health. That is essentially an educational task which we have to attempt. It is only in this direction that we can get the most effective, permanent and satisfying solutions to the problem of health. Let us not forget that drugs and doctors are mere palliatives and not solutions to the problem of health just as armaments and armies are no solutions to the problem of peace. In fact, there is no purely technological answer to the basic problems in life; and we cannot escape the need to provide spiritual solutions to them. A spiritual basis on the lines indicated above is, therefore, inescapable for solving the problems of health care systems. Unfortunately we are not even aware of these dimensions of the problem. To create this awareness and to start moving in this direction can be one of the most worth-while alternatives to explore and implement.

(9) *Pilot Projects*: It is comparatively easy to reach an agreement on the negative conclusion that the existing systems of health care are unsatisfactory. But when it comes to the positive side, viz., development of a new system which would be more in keeping with our national needs and aspirations, it is not possible to reach the same unanimity. In fact, it

is wrong to expect such unanimity which is not needed either. It is but natural that several alternatives might be proposed, that many of them would be viable, and that the differences between them may not be resolved by debate alone. It is, therefore, necessary to adopt a pragmatic approach and to allow trial and support several viable alternatives that meet certain criteria laid down. One thing must be said, however. Any pilot projects that we may undertake must have an adequate scale, say, a whole district to cover. Very small projects may prove nothing; and even if they do, it will hardly be possible to generalize them.

Last year, the Indian Council of Medical Research organized, in collaboration with the Indian Council of Social Science Research, a Seminar on Alternative Systems of Health Care, especially for rural areas. A similar seminar was also organized at New Delhi by the All India Association for the Advancement of Medical Education. Between them, very valuable material has been made available about interesting experimental work now being done in several parts of the country. We have thus considerable experience and expertise in the field and a stage has, therefore, been reached when we can plan pilot projects of adequate size and try them in the Sixth Plan. If properly developed, this programme may enable us to solve the problems satisfactorily in the Seventh or Eighth Plan.

(10) *Expenditure* : The financial aspects of the problem are extremely crucial and our choice of alternatives will depend, not only on their academic value, but on their financial implications as well. Here a few important issues need close examination.

(a) There is no adequate data about existing expenditure on health care systems, their quantum, sources, objectives, rate of growth and such other related but important matters. The distribution of this expenditure by different target groups is also not available. Such studies have, therefore, to be aken up on a priority basis.

(b) The existing expenditure on health care systems is inadequate and will have to be increased. From this point of view, we must prepare a perspective of growth over the next 15 years or so and make some realistic assumption for the Sixth Plan Period. We need a definite lobby to ask for a higher priority and a larger allocation for health.

(c) All possible economies must be effected and costs of health services should be brought down. Simultaneously, we should evolve techniques which increase efficiency and make every rupee go a very long way.

(d) We should permit only a limited increase in these aspects of expenditure on health services where the benefit goes to urban or well-to-do people. In fact, the manner in which a part of this expenditure can be

transferred to urban communities or the beneficiaries themselves should be explored.

(e) The largest share of additional resource that become available should be set aside for taking the health care systems to rural areas or to the deprived sections.

An Appeal

The ten broad principles enumerated above are, in my view, adequate guidelines to develop an alternative system of health care services for India. But we cannot stop with the mere enumeration of such principles. If concrete results are to be achieved, we must take two other steps :

(1) *A large nation-wide debate* should be promoted on the failure of the existing system of health care services, on the reasons for its failure, and on the general principles and major programmes of the alternative system of health care which we must develop.

(2) The Association should set up a competent group to prepare a *Draft Sixth Plan of Health Care Services in India* and submit it to the authorities concerned within one year from now. This will help us to clarify our own thinking and will shed new and valuable light on details which generally tend to be ignored. Quite obviously, such a plan will help in mobilizing public opinion and influencing official policy.

With all the emphasis at my command, I would appeal to the Association to take up these tasks. The Indian Council of Social Science Research would be happy to provide reasonable financial assistance from its project on 'Alternatives in Development'.

Feasibility

An important question will certainly be raised in this context : Will such radical alternatives be feasible or practicable in our situation ? Is the **attempt worth while at all ?** Will it not mean a waste of resources (which are scarce) and of energy (which can be put to other uses) ? These are important issues and need some discussion.

That there are immense difficulties in the development of these programmes is obvious. Among them, I might mention the following :

(a) The existing infrastructure and professional groups have become a big vested interest. It is necessary to make them aware of the issues involved and of the urgent need for alternatives. The most promising aspect of the problem is that there are several persons within the profession itself to extend this awareness of the select few to the profession as a whole and make it a willing and co-operative partner in the programme.

(b) Public opinion has to be educated in favour of these changes. It is our best ally and hope. But the difficulties of doing so are immense, especially in our situation. In particular, we have to get the full moral and political support of the leadership among the weaker sections and deprived groups.

(c) The vested interests of the well-to-do and urban groups who hold the real reins of power would obviously be the biggest hurdle. An appeal should certainly be made to their role of trusteeship and to their enlightened self-interest.

Our instruments to overcome the resistances of the vested interests and the creation of new forces which will support these programmes will be (1) educational propaganda, (2) an appeal to the good sense and social responsibility of the haves, and (3) strengthening of the demands of the have-nots. The first and the third are probably the most effective measures. The ultimate solution, therefore, lies in generating social and political forces which can take the needed decisions and implement them with determination and vigour. I, therefore, agree with Prof. Banerji that the ultimate decisions in health (as in education) are essentially political.

But where do we go from here ? As Prof. C. T. Kurien has pointed out, the situation in India is different from that in the USSR or France. In the USSR, the socio-economic transformation has already taken place and hence the preparation of appropriate health care plans is easy. In France, also, the situation is equally easy because the French people are satisfied with their socio-economic system and do not want to change it. But we are in a different position. We live in the midst of a hierarchical and in egalitarian social order. In spite of all the resistance, we have to prepare alternative plans of development (the usual plans help the status quo) which will help the creation of an egaliterian society and use the plans themselves as instruments of the transformation. This is a difficult but the only possible solution to the problem. Fortunately, it is not beyond a committed band of de-classed intellectuals and the emerging leadership from the masses.

Faced with these realities, I cannot conclude better than with the words of Bhavabhuti who divided all people into three categories : the lowest, the middle, and the highest. He said :

> The *lowest* do not begin for sheer fear of failure. The *middle ones* begin but stop as soon as difficulties arise.
>
> The *highest* begin and never abandon, in spite of repeated blows from difficulties, till success is won.

The *problem* exists; we cannot escape it. The *difficulties* are undoubtedly great; we cannot ignore them. The only choice open to us is to decide

which of these three categories of Bhavabhuti we shall join. I am afraid each one of us will have to answer the question for himself, with our conscience as the sole witness.*

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